

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004426	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2012
NAME OF PROVIDER OR SUPPLIER ADDISON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2244 Q AVE NEW CASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: October 31, November 1 and 2, 2012</p> <p>Facility number: 004426 Provider number: 004426 AIM number: N/A</p> <p>Survey team: Barbara Gray RN TC Sharon Lasher RN Angel Tomlinson RN</p> <p>Census bed type: Residential: 30 Total: 30</p> <p>Census payor type: Other: 30 Total: 30</p> <p>Sample: 7</p> <p>Addison House was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure survey.</p> <p>Quality review 11/05/12 by Suzanne Williams, RN</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1